Personal Support Plan (PSP) Quarterly Review

Name of Person Served	Date	Action Plan Number

Desired Outcome (how the person's life will be different):

Steps that will be taken to reach desired outcome:		**Reporting Period From: To:**	**Reporting Period From: To:**	**Reporting Period From: To:**	**Quarterly Comments:** (Include overall quarterly progress and/or remediation actions.)
	Implemented: Completed:				
	Implemented: Completed:				
	Implemented: Completed:				
	Implemented: Completed:				

The following quarterly reports were presented and reviewed by the Personal Support Team:

☐ Medical report dated: _____

Comments/Changes:

☐ Nursing report dated: _____

Comments/Changes:

☐ Psychology report(s) dated: _____

Comments/Changes:

☐ Drug regimen review dated: _____

Comments/Changes:

☐ Level of supervision (LOS) last reviewed: _____

Current LOS: _____

Comments/Changes:

The following clinics/appointments were scheduled or attended during the past quarter:

Specialty Appointment	Date Scheduled	Date Seen	Recommendation(s)	Comment/Follow-up Needed

Injury Review:

A pattern of injuries ☐ was ☐ was not identified in regard to injuries.

Prevention/monitoring put in place to address identified patterns:

Family Contact:

Qualified Intellectual Disability Professional (QIDP) – On-site Observations/Comments/Action:

Additional Team Discussion:

Additional Recommendations/Decisions:

Personal Support Team Signature Sheet

Team Members	Relationship to the Person
	Supported Person
	Legally Authorized Representative/Advocate
	QIDP